UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS

JUE ZHANG Plaintiff	)	
v.	)	CIVIL ACTION NO. 04-12735-PBS
SHRAGA N. GOLDBERG, M.D. Defendant	)	

PLAINTIFF'S EXPERT WITNESS DISCLOSURE

NOW COMES THE PLAINTIFF, and discloses the expert witness testimony expected in the above captioned matter.

Steven M. Cohen, M.D.
28 Salem Road
Westport, CT 06880

A copy of Dr. Cohen's report is attached.

Dr. Cohen is compensated at a rate of $300.00 per hour for case review, and $600.00 per hour for deposition and trial testimony.

Dr. Cohen has previously testified as follows:

April, 2005: McCormick v. Radiology Associates of Hartford, CT

Michael Marks, M.D.
Coastal Orthopedics
40 Cross Street, #300
Norwalk, CT 06851

A copy of Dr. Marks's report is attached.

Dr. Marks is compensated at a rate of $400.00 per hour. His fee for deposition is $3,750.00 in Norwalk, CT, and $10,000.00 for out of state testimony.

Dr. Marks has previously testified as follows:

Date	Case Name	Type	Location
December, 2002	Wilmerton	Deposition	NJ
October, 2003	Stornelli	Court	NY
November, 2003	Greenwich	Deposition	CT

March, 2005	Johnston	Court	NY
August, 2005	Hitchcock	Court	NY
October, 2005	Still	Deposition	OH
November, 2005	Fearer	Deposition	OH
December, 2005	Geldart	Deposition	FL
February, 2006	Thompson	Deposition	IL
March, 2006	Fearer	Court	OH

Cameron Ashbaugh, M.D.
Division of Infectious Disease
Brigham & Women's Hospital
75 Francis Street
Boston, MA 02115

A copy of Dr. Ashbaugh's report is attached.

Dr. Ashbaugh has not previously testified in Court, and is is charging no fee for testifying in this case.

The plaintiff,
by her attorney,

/S/
Barry D. Lang, Esq.
BBO # 565438
Zachary B. Lang, Esq.
BBO# 652055
Attorney for the Plaintiffs
Barry D. Lang, M.D. & Associates
1 State Street, Suite 1050
Boston, MA 02109
617-720-0176

Steven M. Cohen, MD
28 Salem Road
Westport, CT 06880

October 4, 2004

Barry D. Lang, M.D. and Associates
1 State Street Suite 1050
Boston, MA 02109

Re:Jue Zhang

Dear Dr. Lang,

Thank you for the opportunity to review the above noted case. After review of the CT of the abdomen and pelvis performed on 11/07/01, my findings are as follows:

CT of the abdomen and pelvis was performed after the administration of intravenous contrast material. The liver, spleen, kidneys, pancreas, adrenal glands and pelvic organs are within normal limits except for a probable small right renal cyst. No significant lymphadenopathy is seen in the abdomen or pelvis. On sections 1-6, there is thickening of the right side of the paraspinal soft tissue with suggestion of inhomogeneous sclerotic density within the adjacent lower thoracic vertebral bodies. There is extension of the soft tissue abnormality to the adjacent right sided ribs but no definite bony erosion of the ribs is seen. The findings suggest either an inflammatory or infectious process, with the differential diagnosis also including the possibility of bony neoplasm, particularly lymphoma. Based on the patient's nationality, the possibility of tuberculous infection would need to be considered.

A review of the report issued with respect to the above noted CT was then made. Although I agree with the findings with respect to the viscera in the abdomen and pelvis, there was an omission of the pertinent findings with respect to the soft tissue and bony abnormalities in the lower thoracic spine. This represents a breach of the standard of care by the interpreting radiologists, Drs.Michael P. Goldfinger and Shraga N. Goldberg.

In particular, the final sentence of the issued report states that 'there are no significant osseous abnormalities', which is inaccurate.

After review of the CT and report, I reviewed a report of a CT of the thoracic spine dated 6/20/03 by Dr. Michael Swirsky of Radiology and Imaging, Inc. This report noted progression of the abnormalities delineated above with more extensive bony and soft tissue involvement. The report also noted that there was 'abnormal paraspinal soft tissue thickening in the lower thoracic spine' on the examination performed at Beth Israel Deaconess Medical Center on 11/07/01. This corroborates my findings as well.

Additionally, Dr. Swirsky's report delineated the possibility of tuberculosis as a potential etiology for the findings on both CT scans.

In summary, based on my review of the actual CT scan performed at Beth Israel Deaconess Medical Center as well as the subsequent CT report from Radiology and Imaging, Inc., I believe that significant findings were omitted which constitutes a breach of the standard of care and contributed to delayed diagnosis of tuberculosis in this patient.

Please do not hesitate to call or email me if any further questions arise.

Sincerely,

Steven M. Cohen, MD
Radiologist-in-Chief
Stamford Hospital
Stamford Radiological Associates, PC

Michael R Marks, MD MBA
15 Partridge Lane
Weston, CT 06883
Mmarks1988@aol.com
203-454-4787

September 12, 2006

Dr. Barry Lang
1 State St.
Suite 1050
Boston, MA 02109

RE: JUE ZHANG

Dear Dr. Lang,

I reviewed the records and imaging studies that you provided me with concerning Jue Zhang. I reviewed the December 6, 2004 letter addressed to you from Dr. Cameron Ashbaugh of Brigham & Woman's Hospital Infectious Disease Department who reported the history that this woman provided, that in the summer of 2001 she developed pain in the right upper abdomen and back, in September 2001 made an Emergency Room visit at Metro West Medical Center and was admitted there October 1, 2001 for a variety of imaging studies which were reportedly negative and then November 7, 2001 an abdominal CT Scan done at Beth Israel Deaconess Hospital reported as normal. Symptoms continued and in June 2003 chest and thoracic x-rays showed destructive changes consistent with infection confirmed by a CT Scan of June 20, 2003. She subsequently initiated medical treatment which was unsuccessful and had surgery April 8, 2004 for an anterior debridement and reconstruction. Her condition was identified as being due to tuberculosis and Dr. Ashbaugh rendered the opinion that it was likely that had the diagnosis of tuberculosis been made in 2001 before her disease progressed vertebral body destruction and a large abscess, she would have been able to treated successfully with medical treatment alone and not require surgery.

On October 4, 2004 Dr. Steven Cohen, the radiologist from Stamford Hospital in Connecticut, provided you with a letter reviewing the CT Scan of the abdomen and pelvis from November 7, 2001 and notes that on section 1-6 there is thickening of the right side of the paraspinal soft tissue with a suggestion of inhomogeneous sclerotic density within the adjacent vertebral bodies. He felt that the interpreting radiologist had breached the standard of care by not identifying this abnormality. I presume this particular CT Scan he is referring to of November 7, 2001 was done at Metro West Medical 'Center. He refers to another CT Scan done June 20, 2003 demonstrating progression of changes consistent with infection.

Dr. Cohen had the opinion that significant findings were omitted which constituted a breach of standard of care and a delay in diagnosis resulted from the November 7, 2001 CT Scan report.

I also reviewed April 8, 2004 Brigham & Woman's Hospital, Boston, Massachusetts operative report for the surgery which was performed for anterior debridement and reconstruction with an abscess from T6 to T10 with marked T9 body destruction.

I did personally review the CT Scan of the abdomen and pelvis dated November 7, 2001 and concur with Dr. Cohen's interpretation. The abnormality is seen on scan section 1-6 and shows thickening of the right side of the paraspinal soft tissues in that area with an inhomogeneous sclerotic density in the adjacent vertebral bodies. I did also review the CT Scan of May 6, 2004 which was provided to me which was done after her surgery and shows the spinal reconstruction in the lower thoracic area with anterior hardware.

Based on the information that has been provided to me which is discussed in the text of the report above, it is my medical opinion to a reasonable degree of medical certainty, earlier treatment of the abscess in November, 2001 more likely than not would have prevented spinal destruction requiring extensive surgery.

Sincerely,

Michael R Marks MD MBA

Michael R Marks, M.D. MBA

December 6, 2004

Dr. Barry D. Lang
1 State Street
Suite 1050
Boston, MA 02109

Dear Dr. Lang,

Ms. Jue Zhang has been under my care at Brigham and Women's Hospital from August 2003 for a mycobacterial spine infection. Ms. Zhang was born in China and emigrated to the United States in 1997. She reports that on arrival in the United States she had a skin test for tuberculosis and that she was told that it was positive. In the summer of 2001, she developed pain in the right upper abdomen and back. In September 2001, she made several trips to the Emergency Room at Metrowest Medical Center for evaluation before finally being admitted on 10/01/01. During her admission she had a variety of studies. Reports from these studies record a normal chest x-ray, a normal abdominal x-ray, normal rib x-rays, normal thoracic spine x-rays, and an abdominal/pelvic CT scan that was notable for a possible small cyst in the right ovary. An upper gastrointestinal endoscopy demonstrated findings consistent with mild gastritis. She was discharged on 10/3/01 with a diagnosis of musculoskeletal pain and gastritis. On November 7, 2001, she had an abdominal CT scan done at the Beth Israel Deaconess Hospital. It was reported as a normal study.

She continued to have intermittent back and right side pain that waxed and waned. In June 2003, she initiated care with Dr. Howard Ro in Enfield, Connecticut. On her first visit, Dr. Ro ordered chest and thoracic spine x-rays which demonstrated thoracic vertebral damage that was new in comparison to the x-rays done in 2001. A follow-up spinal CT scan on June 20, 2003 demonstrated findings consistent with a thoracic vertebral spine infection with an associated large paraspinal abscess. Of note, the radiology report compares this CT study to the November 2001 study from the Beth Israel Deaconess Hospital. In retrospect, the radiologist reading the most recent images feels that there was abnormal paraspinal soft tissue thickening in the lower thoracic spine in 2001. The patient underwent needle biopsy of the thoracic spine abnormality on June 26, 2003. The pathology was consistent with mycobacterial infection and the cultures ultimately grew both *Mycobacterium tuberculosis* and *Mycobacterium avium intracellulare* complex. The patient was begun on antituberculous therapy in late June 2003 and in August 2003, additional therapy for *Myçobacterium avium intracellulare* complex was added. Despite medical therapy, she had a slow increase in the size of her paraspinal abscess and thoracic vertebral body infection that was demonstrated by repeated spinal imaging studies over the next nine months.

On April 8, 2004, she underwent a right thoracotomy. In the operating room, approximately 50 ml of purulent material was aspirated from the paraspinal abscess and necrotic bone was debrided. She had a titanium cage and rods placed to stabilize her thoracic spine. A stain of the abscess fluid for mycobacterium species was positive, however, the operative cultures were negative. A PCR test for *Mycobacterium tuberculosis* DNA done on the abscess fluid was positive. A similar test for *Mycobacterium avium intracellulare* complex was negative. The patient has slowly improved since her surgery. She completed medical therapy on 10/15/04.

It is likely that she had slowly progressive mycobacterial spine infection for many years and that the symptoms that prompted her 10/01/01 admission to Metrowest Hospital were due to this infection despite the negative chest, rib, and thoracic spine radiographs that were done at the time. Although the course of these infections is difficult to predict, it is more likely than not that had the diagnosis of spinal tuberculosis been made in 2001, before the disease had progressed to vertebral body destruction and a large abcess, she would have been able to have been treated successfully with medical therapy alone and would not have required surgery

Sincerely,

Cameron Ashbaugh, M.D.
Assistant Professor of Medicine
Harvard Medical School
Associate Physician
Brigham and Women's Hospital
Division of Infectious Disease
Boston, MA